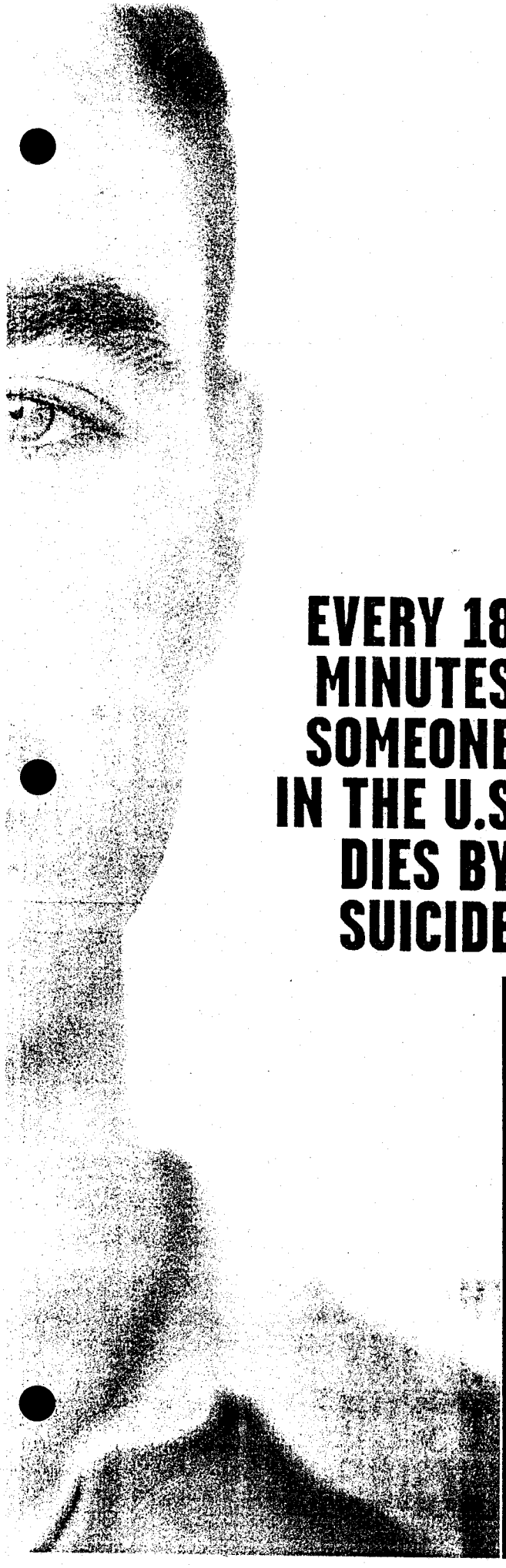
EXHIBIT 8
DATE 1-19-07
HB 2



EVERY 18 MINUTES SOMEONE IN THE U.S. DIES BY SUICIDE.

EVERY 19 MINUTES SOMEONE IS LEFT TO MAKE SENSE OF IT.

National Suicide Prevention and Awareness Week

October 2—7, 2005

Sunday, Oct. 2—Memorial & Awareness Walk
Monday, Oct. 3—Radio talk show, 106.7
QPR Suicide Prevention Training
Video: "Truth About Suicide" & Interview on MCAT
Tuesday, Oct. 4—Video: Suicide Survivors Panel
Video: "Truth About Suicide" on MCAT
Wednesday, Oct. 5—QPR Training
MCAT Panel Discussion
Thursday, Oct. 6—National Depression Screening Day
Film & discussion: Suicide Survivors
Video: "Truth About Suicide" & Interview on MCAT
Friday, Oct. 7—QPR Training
Video: "Truth About Suicide" on MCAT

For specific times & locations see separate schedule or call 258-3881 or 258-4775.

Dr. Gary Mihelish, President
NAMI-Montana
554 Toole Court
Helena, MT 59602
Work: 406-442-4990
Home: 406-458-9738
e-mail: sandym@mt.net

Summary of the 2005 Montana Youth Risk Behavior Survey High School students administered by the Office of Public Instruction.

25.6 % of the surveyed students in Montana felt so sad or hopeless for two week or more in a row they stopped doing some usual activity during the past 12 months.

17.5% of the surveyed students in Montana seriously considered attempting suicide during the past 12 months.

14.6% of the surveyed students in Montana made a plan about how they would attempt suicide during the past 12 months.

10.3% of the surveyed students in Montana actually attempted suicide during the past 12 months.

3.1% of the surveyed students in Montana had a suicide attempt resulting in injury, poisoning, or overdose that required medical treatment in the past 12 months.

If you don't believe these statistics, just ask your daughter, son, grandson, granddaughter, niece, newphew or the next door neighbor kid what their thoughts are!

Summary of the 2006 Prevention Needs Assessment Survey Administered by Department of Public Health and Human Services.

30% of surveyed students in Montana sometimes think life is not worth it.

40.6% of surveyed students in Montana at times think they are no good at all.

18.7% of surveyed students in Montana "All in all, I am inclined to think I am a failure."

38.7% of surveyed students in Montana in the past year, have felt depressed or sad MOST days, even if they felt OK sometimes.

1/4/2007

NAMI montana
PO Box 1021
Helena MT 59624
(406) 443-7871
namimt@ixi.net

SUICIDE IN MONTANA

Suicide is a tragic and potentially preventable public health problem. Nationwide, someone dies from suicide every 17 minutes. While there are 17,000 homicides in the United States each year, there are 30,000 completed suicides. Research has shown that more than 90 per cent of people who kill themselves have depression or other diagnosable mental disorder or a substance abuse disorder in combination with other mental disorders.

Last year alone, over 7 percent of youth – 1.8 million – had thoughts about killing themselves during their worst or most recent episode of major depression. Approximately 900,000 youth made plans to commit suicide: 712,000 acted on those plans by attempting suicide.

The State of Montana annually ranks 2nd or 3rd nationally in the rate of suicide. The leading cause of death in the 10-14 age groups in Montana is suicide. In the 15-24 age groups, suicide is the second leading cause of death after accidents.

During the 2007 Montana Legislature, legislation will be introduced to develop suicide prevention programs in Montana. It is my hope each legislator would support or sponsor such legislation. Suicide is a bi-partisan issue. It affects Democrats and Republicans equally.

"Suicide is not chosen; it happens when pain exceeds resources for coping with pain."

Sincerely,

Dr. Gary L. Mihelish, President
The National Alliance on Mental Illness of Montana (NAMI-MT)

GUEST /OPINION

State must take better care of the mentally ill

By GARY MIHELISH

Suicide has hit the front page in Montana newspapers recently.

Four of them have occurred at the Montana State Prison in the last eight months. And on Friday, Jan. 29, Gov. Judy Martz and Gail Gray, director of the Department of Public Health and Human Services, held a press conference dedicated to prevent teen suicides in the state of Montana.

Montana annually has the second- or third-highest suicide rate in the country. A check with the Bureau of Vital Statistics shows that in 2002 the 182 suicides were second only to the 269 deaths caused by traffic accidents in Montana. That year there were eight AIDS-related deaths and two deaths caused by Hantavirus. So why does Hantavirus get the headlines?

Why is there such a high suicide rate in Montana?

Director Gray said that isolation in the state is an issue, as well as easy access to vehicles and firearms.

This may be true, but it is not the *cause* of suicide.

Gov. Martz said, "They are looking for a permanent solutions to a temporary problem."

I would argue that in most cases it is a permanent solution to a long-standing problem.

Replicated studies by the National Institute of Mental Health and others have shown that 90 percent of suicides are related to undiagnosed, untreated or inadequately treated mental illness. This would mean 164 Montana suicide deaths could be related to untreated, or inadequately treated mental illness. This is a staggering number.

2002 Deaths

Traffic	269
Suicide	182
Suicide and mental illness	164
AIDS	8
Hantavirus	2

Source: DPHHS

What do we do about this situation? The governor was absolutely right when she said: "It is not about money. It's about education and it's about awareness." What we need in the state of Montana is a change of attitude. We need to address suicide and mental illness in the open.

First, we must accept that mental illnesses are real. They actually exist. National studies indicate one in five Montana families has been touched by mental illness.

These are biologically based illnesses, which can be treated with medication and appropriate psychotherapy. People do recover from these illnesses and become productive citizens if they can get the appropriate treatments.

Getting the appropriate treatment is the problem.

Because many of the people receiving treatment are on Medicaid, the public mental health treatment system must be funded adequately.

Last week, Warden Mike Mahoney stated 18 percent of the prison population suffered from a mental illness.

The stigma associated with mental illness prevents people from seeking appropriate treatment.

I would argue the suicide rate in Montana will not change until we treat people with mental illness appropriately, whether in the public mental health system or in the correctional system. Now all we have to do is be committed to that effort.

Dr. Gary Mihelish, a Helena dentist, is president of the Montana chapter of the National Alliance for the Mentally Ill in Helena.

GREAT FALLS TRIBUNE • WWW.GREATFALLSTRIBUNE.COM Sunday, February 15, 2004

OPINION

is:
lan
6600

National Institute of Mental Health

NATIONAL INSTITUTES OF HEALTH

Dr. Gary Mihelish, President
NAMI-Montana
554 Toole Court
Helena, MT 59602
Office: 406-442-4990
Home: 406-458-9738
e-mail: sandym@mt.net

In Harm's Way: Suicide In America

A brief overview of suicide statistics and prevention.

2003 (rev)

In Harms Way: Suicide In America

Suicide is a tragic and potentially preventable public health problem. In 2000, suicide was the 11th leading cause of death in the U.S.[1] Specifically, 10.6 out of every 100,000 persons died by suicide. The total number of suicides was 29,350, or 1.2 percent of all deaths. Suicide deaths outnumber homicide deaths by five to three. It has been estimated that there may be from 8 to 25 attempted suicides per every suicide death.[2] The alarming numbers of suicide deaths and attempts emphasize the need for carefully designed prevention efforts.

Suicidal behavior is complex. Some risk factors vary with age, gender, and ethnic group and may even change over time. The risk factors for suicide frequently occur in combination. Research has shown that more than 90 percent of people who kill themselves

have depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorders.[2,3] Also, research indicates that alterations in neurotransmitters such as serotonin are associated with the risk for suicide.[4] Diminished levels of this brain chemical have been found in patients with depression, impulsive disorders, a history of violent suicide attempts, and also in postmortem brains of suicide victims.

Adverse life events in combination with other risk factors such as depression may lead to suicide. However, suicide and suicidal behavior are not normal responses to stress. Many people have one or more risk factors and are not suicidal. Other risk factors include: prior suicide attempt; family history of mental disorder or substance abuse; family history of suicide; family violence, including physical or sexual abuse; firearms in the home; incarceration; and exposure to the suicidal behavior of others, including family members, peers, or even in the media.[2]

Gender Differences

Suicide was the eighth leading cause of death for males and the 19th leading cause of death for females in 2000.[1] More than four times as many men as women die by suicide,[1] although women report *attempting* suicide during their

Suicide by firearm is the most common method for both men and women, accounting for 57 percent of all suicides in 2000. White men accounted for 73 percent of all suicides and 80 percent of all firearm suicides.

Children, Adolescents, and Young Adults

In 2000, suicide was the third leading cause of death among 15- to 24-year-olds—10.4 of every 100,000 persons in this age group—following unintentional injuries and homicide. Suicide was also the 3rd leading cause of death among children ages 10 to 14, with a rate of 1.5 per 100,000 children in this age group. The suicide rate for adolescents ages 15 to 19 was 8.2 deaths per 100,000 teenagers, including five times as many males as females. Among people 20 to 24 years of age, the suicide rate was 12.8 per 100,000 young adults, with seven times as many deaths among men as among women.[1,6]

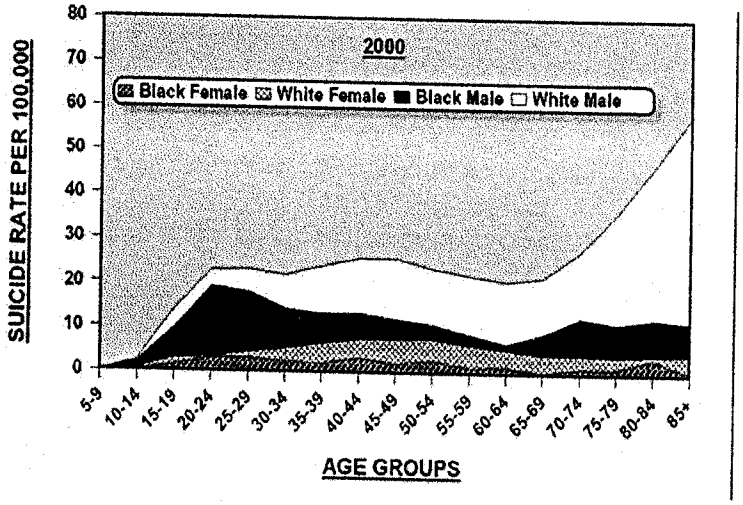
Older Adults

Older adults are disproportionately likely to die by suicide. Comprising only 13 percent of the U.S. population, individuals age 65 and older accounted for 18 percent of all suicide deaths in 2000. Among the highest rates (when categorized by gender and race) were white men age 85 and older: 59 deaths per 100,000 persons, more than five times the national

Attempted Suicides

Overall, there may be between 8 and 25 attempted suicides for every suicide death; the ratio is higher in women and youth and lower in men and the elderly.[2] Risk factors for attempted suicide in *adults* include depression, alcohol abuse, cocaine use, and separation or divorce.[7,8] Risk factors for attempted suicide in *youth* include depression, alcohol or other drug use disorder, physical or sexual abuse, and disruptive behavior.[8,9] As with people who die by suicide, many people who make serious suicide attempts have co-occurring mental or substance abuse disorders. The majority of suicide attempts are expressions of extreme distress and not just harmless bids for attention. A suicidal person should not be left alone and needs immediate mental health treatment.

U.S. Suicide Rates by Age, Gender, and Racial Group



Prevention

Preventive efforts to reduce suicide should be based on research that shows which risk and protective factors can be modified, as well as which groups of people are appropriate for the intervention. In addition, prevention programs must be carefully tested to determine if they are safe, truly effective, and worth the considerable cost and effort needed to implement and sustain them.[10]

Many interventions designed to reduce suicidality also include the treatment of mental and substance abuse disorders. Because older adults, as well as women who die by suicide, are likely to have seen a primary care provider in the year prior to their suicide, improving the recognition and treatment of mental disorders and other suicide risk factors in primary care settings may be one avenue to prevent suicides among these groups.[11] Improving outreach to men at risk for suicide is a major challenge in need of investigation.

Recently, the manufacturer of the medication clozapine received the first ever Food and Drug Administration indication for effectiveness in preventing suicide attempts among persons with schizophrenia.[12] Additional promising pharmacologic and psychosocial treatments for suicidal individuals are currently being tested.